Letters

Report on the 12th National Rural Health Conference Hosted by the Beaufort West Community 18–20 September 2008

RuDASA Organising Committee, from left to right: Mrs Anne Stander, Nursing Services Beaufort West Hospital; Mrs Michelle Bothma, Nursing Services Beaufort West Hospital; Mr Nathan Wilson, Ukwanda; Mrs Tina Eikerman, Stellmed; Mrs Sonja Niemandt, Stellmed; Mrs Alta Jonker, Matron Beaufort West Hospital; Dr Earle du Plooy, Medical Superintendent Beaufort West Hospital. Dr Louis Jenkins took the photo.

The conference was well attended by 220 health care workers, including many nurses, doctors, managers, radiographers, physio- and occupational therapists, one technologist, and about 40 medical students.

All the provinces in South Africa were represented, except the Northern Cape, from which it was simply impossible to recruit one health care worker.

The conference was made possible through the generous donations from the University of Stellenbosch, the Holland Stellenbosch Medical Foundation, the Africa Health Placements Project, the HIV Clinicians Society, Aspen, Abbot, and Sandoz.

The efficiency, enthusiasm, optimism, and dedication towards district health in this rural town of Beaufort West by the local health team, as well as everyone who attended, and the speakers, left everyone who attended encouraged and uplifted to continue to care and work out the challenges in public health in our country.

The **plenary speakers** included Prof Ian Couper who spoke on the rural health team, Dr Rajamani from India who spoke on primary health care, Prof Steve Reid who spoke on research in rural health, Prof Pierre de Villiers who spoke on the training of family physicians in South Africa, Dr Jono Pons who illustrated the eye service in Swaziland, and Dr Stefan Gebhardt who took us through pregnancy and delivery in a rural setting, making it safe for women and their babies. Some of the memories from these excellent presentations are worth noting.

Prof Ian Couper illustrated the health team in various ways, with the picture of a spider web resembling the team as the final image. His Kenyan quote of "sticks in a bundle don't break" illustrated well the strength of working together. The five kinds of "team" health care workers were most informative: 1. The Easy-going Australian Model, 2. The Energetic Asian Model, 3. The Enthusiastic American Model, 4. The Enigmatic African Model, and 5. The Elusive Antarctic Model.

Prof Steve Reid taught the audience a song, which was not very unusual, and great fun! His talk on research emphasised curiosity and the value of asking questions. He started with a very apt quote: "The fatal pedagogical error is to throw answers like stones to those who have yet to ask questions." He spoke about being "present" in the consultation, being in a place of opportunity in one's thinking, right there in the seemingly monotonous OPD queue in a busy district hospital. Two examples included the old woman with vague complaints, but who was actually concerned about her pension not stretching to meet the needs of the nine children she cares for; and the younger woman, with lower abdominal pain, not asking the unthinkable question: "Could I have HIV?" Are we thinking of those questions? Prof Reid ended his presentation with another far-reaching quote from Eudora Welty: "My continuing passion is to part a curtain, that invisible veil of indifference that falls between us and that blinds us to each other's presence, each other's wonder, each other's human plight."

A very good **panel discussion on advocacy** was lead by Dr Bernhard Gaede (recent chairperson of RuDASA), Prof Steve Reid and Prof Ian Couper. Dr Gaede made the point that "Wanting to care for people, like Drs Colin Pfaff at Manguzi and Dr Thys Von Mollendorf at Rob Ferreira Hospital (a few years ago) had done (in providing ARVs), becomes a political act (without necessarily trying to challenge anyone)." Prof Reid summarised the six RuDASA advocacy priorities.

Prof Pierre De Villiers gave a very encouraging presentation on the progress with training of family physicians in South Africa. The Western Cape Department of Health, together with the Universities of Stellenbosch and Cape Town, have formed a partnership in which five training complexes have been developed. Every year, 20 supernumery Family Medicine registrar posts are created in the Western Cape districts, within the framework of a MMed (Family Medicine), direct training supervision by specialist family physicians, and district and regional service delivery.

Dr Jono Pons, the eye doctor for Swaziland, and 20% of Mpumalanga province, it seems, certainly challenged me the most in terms of staying realistically optimistic and extremely pragmatic and caring, in the face of overwhelming challenges. One of the principles he expounded included: "There is no waiting list." Time in Africa is actually expensive. Perhaps not purely monetary, but for a granny (often also the single care giver to an orphan), to travel two days over hills, to attend an eye clinic with her blindness due to cataracts, this is a huge outlay. She must be helped at the point of care, within a day or two – not told to come back another day for surgery. Another principle was: "Even a poor man has a gift to offer." There is always someone in a worse position than oneself. Hence, Swaziland reaches out to Mozambique, to the extremely underserved Zambezi delta. Another truth: "Skills do not equal value." The doctor with a set of skills must not overestimate his/her value in the team. The porter, with skills of communication, plays as important a role in caring for the patient. Finally, Dr Pons made the point that in order for doctors (and other members of the health team) to stay in touch with their patients' world, and to prevent us from becoming arrogant

and judgmental, we should get into the community and homes of our patients at least once a month. "We need a regular dose of community."

Dr Stefan Gebhardt took us on a comprehensive journey of maternal and baby care, making the point that we know why mothers and babies die, but the question is: "Why don't we do something about it?" He explained BANC, PIPP, PEP, ESMOE, Partogram, CTG, VBAC, and the maternity case record – all tools to improve safety of maternal care.

Mr Marius Fransman, the MEC for Health in the Western Cape, gave a very good presentation on the main issues of health facing our communities. He made the point that we need to get it right at the level of the factors driving the disease, for example housing issues, road traffic accidents, and alcohol abuse. (Why are 45 % of pregnant women in the Western Cape still using alcohol?)

Antoinette Pienaar entertained the Conference delegates on Friday night, at the Beaufort Braai. Her one quirk that struck me was: "As jy wil sien in die Karoo, moet jy 'n bietjie verder kyk."

Dr Dave Spencer gave a very good and detailed talk on the world of **ARV resistance,** taking us through the evolution of the R5 virus to the X4 virus. He highlighted the reality of the compartmentalisation of the HI virus – that we only have access to about 2% of the virus (in the serum). The rest is hidden in the cells in the body compartments. He reminded us "even if our patients speak English, they still don't speak 'my' language". He made the point that this virus "let's us examine our fault lines, fault lines in politics, in families, and in me".

Drs Trevor Gould and Danie Theron gave a very good talk on **TB.** We were reminded that SA is sitting with the highest TB prevalence in the world, around 1000/100 000 cases/population. One per cent of all new TB cases are now MDR-TB, and 4% of re-treatment cases are now MDR-TB. The three useful questions to ask in TB patients with possible DILI (Drug-induced liver injury) are: 1. Is the patient at risk? 2. Does the patient have symptoms of DILI on TB treatment? 3. How severe is the patient's TB?

The extremely useful place of a sonar examination of the spleen in the diagnostic dilemma of the ill, HIV positive patient with sputum negative suspected TB was well illustrated with the study at Brewelskloof in Worcester. The take home message included:

- Communication between ARV sites, TB sites, hospitals is vital.
- Further investigation is indicated in symptomatic HIV patients despite negative sputa.
- CRP is a useful marker pre-ARVs.
- IRIS is common in advanced HIV.
- Try for bacteriological diagnosis.
- Follow your patient up if you started Rx without bacteriologic diagnosis.

The classification of monitoring response to TB treatment was also very interesting: At eight weeks post therapy, there should be two or more of: 5% weight gain, Hb rise of 1g/dl, performance score increase of 20, decrease in CRP, symptom count ratio of 0.5.

Prof Tony Westwood ran a workshop on **Rapid Rehydration** in children with acute diarrhoea, speaking from the Red Cross Children's hospital experience. The aim is to completely rehydrate the child within four hours, per nasogastric tube, at a rate of 15 mls/kg/hr (5% dry) to 30 mls/kg/hr (10% dry). Very few complications have resulted from this protocol. He emphasised ongoing milk feeds, the importance of Vit A, and of course zinc supplementation.

Dr Ilse Els presented a very good workshop on **CPAP in Neonates:** CPAP (from delivery) is a vital tool in preventing hyaline membrane disease in low birth-weight infants. Suggestions were presented as to how CPAP could be made available at district hospitals and in EMS units cheaply and practically.

The **Completion of the Death Notification Form** workshop was very helpful. Explanation of terminology involved in death notification, reasons why accuracy is important, case studies and difficult scenarios, discussions, and recommendations for improving quality especially M&Ms and ward round discussions on diagnosis sequencing, was discussed.

Student workshop: Each campus gave an overview of rural outreach activities that they are involved with. Discussions were held to decide on a structure for a permanent student committee to function within RuDASA. One Representative from each campus will sit on a virtual student committee and form the link between RuDASA student representatives and rural health clubs. Students will maintain contact to keep each other updated on their current projects, and will focus together on how to improve rural electives and exchange programmes. A second RuDASA student representative was elected, viz Nathi Mkize from UKZN. Welome Nathi! The students will meet again this time next year.

Career path of Clinical Nurse Practitioner: This was a comprehensive discussion on the expanding role of the CNP in the shift from primarily curative care to a holistic community approach to health, with emphasis on the importance of continuing education for CNPs, and their involvement in a broadening scope of practice in order to better serve and empower the communities they work in.

The role of the GP in rural health: The question put to the audience was: 'Are private practitioners necessary in rural health?' The unanimous answer was 'YES!', and various challenges were discussed.

- Positives: Older GPs training younger doctors, taking pressure off overburdened government sector.
- Negatives: GPs not following government protocols, misconceptions regarding GPs 'stealing/exploiting' government/low SES patients.
- Challenges: Government's seeming reluctance for GPs to work in hospitals, mutual mistrust and need to establish common forum for discussion.

Some of the conclusions for this session were: Issue to be forwarded to RuDASA as possible advocacy project – support for the private rural practitioner (especially with regards to dispensing and locums), addressing Article 18 as barrier to private participation in public hospitals. Possible plenary session at next conference on these topics.

The workshop on **Fine Needle Aspirations** (FNA) by Dr Gillaume Swart was very well presented. FNA is a simple, cost effective technique to diagnose diseases associated with any masses or lumps in the human body. It is SAFE, and can be practiced effectively by anyone who has undergone the correct orientation within 90 minutes. Basically, cells are collected through aspiration of a mass or lump using a fine needle, and fixed onto a glass plate for histopathological analysis. FNA-based diagnosis is often complicated by a lack of information regarding detailed patient histories, e.g. patients diagnosed involving HIV/AIDS or cancer. The workshop was attended by 10 delegates who had a chance to practice the technique on chicken breasts.

This presentation by Nurse Lecturer Nomasonto Magobe was a report on a study employing a mixed methodological research design, i.e. using both quantitative and qualitative methodology. The main research questions were: "What are your **perceptions with regard to reasons for poor clinical competencies**" and "Why are PCNs/PHCNs in our clinics having poor clinical competencies?"

The main findings were:

1. There is a lack of continuing education
2. There is a lack of feedback from referral sources
3. There is a lack of appropriate qualifications
4. There is a lack of adequate staffing and equipment

The conclusion of this thought-provoking presentation was that PCNs (Primary care nurses = all nurses in a primary care facility) experience unbearable loads of work due to the factors mentioned above, accompanied by poor quality control, and that means must be sought to address this dilemma.

A paper presented on **Competency requirements of the Clinical Nurse Practitioner** to realise a nurse driven service, in a similar context as the above research concluded:

- Competency requirements of the Clinical Nurse Practitioner, to ensure the continuous delivery of quality of care, cannot be obtained by means of a Diploma qualification only
- The continuous improvement (doing it better) and maintenance (re-learning, new-learning, not forgetting how to) of competence in practice remains essential, therefore
- Challenges hampering learning should be overcome by nurturing the essence of a learning culture

Professional Nurse Buyisile Mdhlovu presented a free paper on a study conducted to assess the **Attitudes of professional nurses towards getting tested for HIV.** The results showed disturbing responses indicating that many professional nursing staff are HIV-positive, most of whom have decided to keep it a secret and 'live alone with the disease', in fear of the stigma attached to the disease. In fact, some audience members related how they lost staff members to HIV/AIDS, with professional staff being unable to declare their status openly. The presenter expressed a sincere wish for funding and support that will enable her to establish support groups for professional nurses (e.g. Nurse-to-Nurse support group).

Dr Andrew Trustcott attended the SA Family Practice Conference in Rustenberg (August 2008), and for the purpose of the RuDASA audience, he summarised some **methods of training nurse clinicians** (PHC nurses) based on experiences in Soweto. In collaboration with Steve Reid, a few proposals were suggested for teamwork and training of PHC nurses. Andrew illustrated teamwork using a five minute role playing act, which involved the audience to a high degree of interaction.

Dr Colin Pfaff presented a paper on the **PMTCT programme at Manguzi hospital.** It was fascinating to hear what is possible to do with a team. They provide integrated care at clinic level for pregnant mothers. Opt out HIV testing is part of the first antenatal visit. If the woman tests positive, blood for a CD4 count is drawn together with the other antenatal bloods. The further care with PMTCT is integrated into the antenatal care at the clinic.

Dr Wessels and Sr de Swardt presented on the **HIV care team.** Their message was back to basics, we need a team that communicates well, and the usefulness of a chronic care model for HIV care.

Dr Gunther Winkler did a fascinating presentation on the dilemma of a psychiatric patient who refuses treatment and is a burden to his family, but is not dangerous. The audience discussed various management options such as involuntary outpatient care, and even "finding him a wife"!

Prof Ian Couper presented his **evaluation of a Comprehensive Community Clerkship on Canada.** In a graduate four year programme, third year medical students do a community placement for eight months. They are placed in groups of four per site with a site coordinator that provides continuity. The mentorship relationship between students and preceptors is considered important, as "an opportunity for values to rub off". The lessons for us in South Africa include that rural exposure has advantages such as learning skills, continuity of care, teamwork and community involvement. In the design of such a programme, flexibility needs to be balanced with guidelines.

Dr M Kunneke presented the **Paediatric ChildPIP** report on the Child Problem Information Project as implemented in the Boland Overberg Region of the Western Cape. She demonstrated how this programme is easy to implement in district hospitals. It is a mortality audit tool for children. Through this programme child mortality can be audited. The message was: If you would like to make a difference to the care given to sick children, consider implementing the Child Healthcare Problem Identification Programme (ChildPIP) in your hospital. For more information visit: http://www.childpip.org.za/

Dr Gert Marincowitz presented a description of a **chronic care audit tool** implemented in Tzaneen, Limpopo. By allocating two days a month the family physician and his team showed a substantial improvement in the control of chronic patients.

Dr Steyn presented an audit of the use of inhalers in adult patients. Not just patients, but also health personnel, especially doctors had a very poor technique. This improved through individual and group education and through the use of a video.

Drs H Louw and C O'Reilly presented a model of the **integration of home based and inpatient palliative and step-down care** in George through a NGO. Good cooperation between the NGO and the state health services was a key to the success of the programme.

Dr Stanford presented an approach to **palliative care** as implemented in Knysna and gave very valuable practical examples of palliative care in practice using a team approach.

The Asthma workshop, presented by Prof Bob Mash, was excellent. It was very practical and interactive with case scenarios to illustrate points. The slides were easy to follow and the information very relevant for PHC. Each participant was able to practise using an inhaler. Some of the key issues were:

- Often underestimated and underdiagnosed.
- Diagnosis: history most reliable.
- Important to differentiate between asthma and COPD.
- Main comparisons made between asthma and COPD in the history.
- Importance of establishing reversibility.
- Main investigations: PEFR essential at every visit.
- CXR – useful to determine previous diseases (i.e. diseased lungs) or assist with co-morbid conditions (e.g. cardiac failure, Ca lung).
- Treatment guidelines: new classification used.
- Important to assess control at each visit – well controlled, partly controlled or uncontrolled. Treatment will be determined by level of control.
- Cornerstone of treatment: steroid inhaler.
- Routine questions that the health care provider should ask to assess control:
  - How many times in the week do you get asthma symptoms during the day
  - How many times in the week do you get asthma symptoms at night
  - How many times in the week do you use Ventolin®
  - How often during the week have you been off work due to symptoms (i.e. limitation of daily activities)
  - Have you had to attend a health care centre as emergency in the last month
  - Assess PEFR (according to age and height)

"7 habits of highly effective asthma doctors"

1) Check inhaler technique yourself
2) Assess understanding and use of medication: relievers vs controllers
3) Consider aggravating factors/triggers
4) Consider co-morbid conditions e.g. GI reflux, rhinitis or sinusitis, cardiac disease
5) Consider stepping up treatment
6) Consider need for oral steroids
7) Offer self management plan i.e. involve the patient in treatment outline/goals

The **Stroke workshop** was presented by the team from Worcester in the Western Cape (Klusman, Hoffie Conradie, et al).

Background: world-wide second commonest cause of death with 2/3 of strokes occurring in the developing world. Fifty per cent of survivors are left with chronic disability.

Risk factors discussed: HPT, smoking, hypercholesterolaemia.

Types of stroke: cerebral (infarction or haemorrhage) or subarachnoid.

The session was then divided up between the team, each sharing how they assist in managing the acute stroke patient, until they are back in the community.

Family physician
Physiotherapist
Occupational therapist
Speech therapist

Some issues that were stressed:

- importance of team work
- importance of communication
- involvement of community members from early on in the rehab programme, including community place health care professionals
- importance of good referral patterns
- education to family members and the community

The session provided an amazing example of team work, involving specialists, family physicians and allied health care workers. It wasn't very interactive, but questions were taken at the end of the session. Perhaps many people working elsewhere were left feeling rather despondent, as this model seems to work so well with such good results, which contrasts sharply with how patients with strokes are managed in most hospitals in the country!

Dr E du Plooy gave an excellent, multi-medial presentation on the '**Use of Information Technology** in the Rural Setting in doing Presentations', proving that creating a digital slide show can well compete with other creative arts. Ranging from basic science on additive and subtractive colours to the psychology of the presentation, he left the audience with a wealth of new insights on how to improve one's presenting skills.

At the last session, Mr N Wilson motivated the attending rural practitioners to bring '**Medical Education and Research** in Rural Health' onto the agenda. In the form of a brain-storming, he asked all listeners to suggest three possible topics from their own setting. After some discussion about facilitating factors and challenges, it was agreed to forward the matter in the way that RuDASA establishes itself as a platform and promoter for research on 'rural health issues'. This is to be developed during the coming year and should result in a research agenda as well as in an infrastructure to support researchers in a rural setting.

Conclusion

This conference was a healthy mix of clinical, advocacy, and caring issues, within the context of the health care team. It was well represented by most categories of staff, provinces, and a good number of students. Hopefully next year's conference will be building on the Beaufort West experience!

Louis Jenkins